Illinois Department of Human Services **Illinois Department of Public Aid**

Mail-In Application for Medical Benefits

(Esta solicitud está disponible en español.)
(This application is available in Spanish.)

Medical benefits are available to eligible persons who need help paying their medical bills. Anyone who wants to apply for medical benefits may use this application.

This is **NOT** an application for cash assistance or food stamps. If you want to apply for those programs, contact your local Department of Human Services (DHS) office.

WHAT MEDICAL SERVICES ARE COVERED?

Most needed medical services are covered. Payment will not be made for services that are free or paid for by another source, like health insurance. The following services are covered:

- hospital care
- nursing facility care
- doctor services
- prescription drugs
- shots and check-ups for children
- care at clinics
- physical occupational and speech therapy
- laboratory tests and x-rays
- help for alcohol and substance abuse
- medical equipment, supplies and appliances
- medical transportation
- hospice care
- home health care services
- renal dialysis
- family planning
- eye care
- podiatry care
- dental care
- chiropractic care
- audiology services
- mental health care

WHERE CAN YOU GET THESE MEDICAL SERVICES?

You may go to any medical provider who accepts payment from the Department of Public Aid.

HOW LONG DOES THE APPLICATION PROCESS TAKE?

If you are applying because you have a disability, DHS will send you a notice to tell you if you are eligible for medical benefits within 60 days of the date you apply. If you do not have a disability, the notice will be sent within 45 days.

WHERE DO YOU SEND THIS APPLICATION?

Mail the application to your local DHS office. If you do not know the address, call toll-free 1-800-252-8635. Persons using a teletypewriter (TTY), call toll-free 1-800-447-6404.

INSTRUCTIONS: Read the application carefully and follow all instructions.

1. A separate application must be completed for each person who is blind, has a disability or is age 65 or older.

2. **Complete pages 1 - 5 of the application.** Depending on your situation, also complete the attached Forms A - G. Be sure to mail all documents together. Answer questions completely and accurately. If you cannot answer all of the questions, fill out as much as you can. If you need more space to answer questions, attach an extra sheet. If you have questions, call your local Department of Human Services (DHS) office or call toll-free 1-800-252-8635. Persons using a TTY can call toll-free 1-800-447-6404.

   < Complete **Form A** if anyone applying for medical benefits has Medicare or other health insurance.

   < Complete **Form B** if anyone applying is blind, has a disability or is age 65 or older.

   < Complete **Form C** if anyone applying lives in a long term care facility or a supportive living facility or intends to move to a long term care facility or a supportive living facility, or receives or has applied for services through the Department on Aging's Community Care Program. Complete **Form D** if the person is married.

   < Complete **Form E** if anyone applying is blind, has a disability or is age 65 or older and is employed **or** if a responsible relative living with the person is employed. A responsible relative is a spouse or a parent of a child younger than 18.

   < Complete **Form F** if anyone applying is married, but does not live with his or her spouse.

   < Complete **Form G** if you are applying for a child who is already covered by health insurance or for whom you have arranged for health insurance to begin soon.

3. Sign the application.

4. Attach copies of any required documents to the application. See pages 3 and 4.

If you are not satisfied with the actions taken on this application, you have the right to a fair hearing. You can ask for a fair hearing by calling 1-800-435-0774 (if using TTY: 1-877-734-7429) or by writing to : Illinois Department of Human Services, Bureau of Assistance Hearings, 401 South Clinton Street, 6th Floor, Chicago, IL 60607.

Medical benefits programs comply with all state and federal laws, rules and regulations pertaining to equal access regardless of sex, race, disability, national origin, religion, or age. The State of Illinois provides reasonable accommodations according to Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act of 1990.

To file a complaint of discrimination, contact the Illinois Department of Human Services (DHS), Illinois Department of Public Aid (DPA) or the U.S. Department of Health and Human Services (HHS). Write DHS at Department of Human Services, EEO/AA Office, 401 South Clinton Street, 3rd Floor, Chicago, Illinois 60607. Write DPA at, Department of Public Aid, EEO/AA Office, 401 South Clinton Street, 7th Floor, Chicago, Illinois 60607. Write HHS, Director, Office for Civil Rights, Room 506-F, 200 Independence Avenue, S.W. Washington, D.C. 20201 or call (202)619-0403 (voice) or (202)619-3257 (TTY). DHS, DPA, and HHS are equal opportunity providers.

INFORMATION TO INCLUDE WITH THE APPLICATION

To get medical benefits, you must provide proof for some of the information you give. Please attach copies of the following documents with this application. Do not send originals. Include all that apply**.**

- **Income** - Send proof of each type of income listed on the application. If the person applying lives with his or her spouse, include the spouse's income. This may include:

  - Copies of pay stubs for earnings and proof of tips received during the last month. If anyone is self-employed, provide detailed business records that include income and expenses for the last month.
  - Copies of checks for the last month or award letters for Unemployment Benefits, Social Security Benefits and Veteran's Benefits.
  - Copies of checks for the last month or a support order for spousal or child support.
  - Proof of other income including income from trusts, pensions, rental property, etc. Also send proof of expenses tied to rental income.

- **Support Paid** - To get credit for spousal or child support paid, provide proof of payments made in the last month.

- **Child Care Expenses** - If anyone applying for medical benefits pays for child care so they can work, provide proof of payments made in the last month so that they can get credit for those expenses.

- **Immigration Documents for Non-Citizens** - If anyone applying for medical benefits is not a U.S. Citizen, provide proof of their immigration status. Proof is a copy of any one of the following:

  - Alien Registration Receipt Card/Permanent Resident Card/Green Card (INS-3A); or
  - Passport with the following stamps or attachments: Arrival-Departure Record with the stamp showing status (I-94), or Resident Alien Form (I-151 or I-551), or Temporary Resident Card (I-688); or
  - A court ordered notice for Asylees; or
  - INS documents with an A-number; or
  - Other proof of lawful immigration status.

  A pregnant woman is not required to provide proof of immigration status.

  Other adults who want medical benefits must provide proof of their immigration status. We will contact the U.S. Immigration and Naturalization Service to check their status. Adults must also have been in the U.S. for at least five years. The state can only cover medical care provided in an emergency if we cannot verify an adult's legal immigration status or they have been in the U.S. less than five years.

- **Proof of Pregnancy** - If anyone applying for medical benefits is pregnant, provide a signed statement from her doctor or health clinic that includes the date she is expected to deliver and the number of babies expected.

- **Proof of Application for a Social Security Number** - If anyone applying for medical benefits does not have a Social Security Number, provide a signed statement from the Social Security Administration that application for a number has been made.

- **Medicare or Other Health Insurance** - If anyone applying has Medicare or other health insurance, complete the attached **Form A** or provide a copy (front and back) of the Medicare card or health insurance card. If anyone can get free health insurance through a job or union, provide information about the plan and qualifications.

INFORMATION TO INCLUDE WITH THE APPLICATION (cont.)

If anyone applying is blind, has a disability or is age 65 or older, provide proof of the following information if it applies.

- **Age** - If anyone applying for medical benefits is age 65 or older, provide proof of age. This may include a copy of the person's birth certificate, Social Security records, passport or Veteran's Administration records.

- **Disability** - If anyone applying for medical benefits has a disability, provide proof of disability. If they get Supplemental Security Income (SSI), or Social Security Disability Insurance (SSDI) benefits, they do not have to provide other proof of disability. If the person does not get SSI or SSDI benefits, provide a current medical report.

- **Employment Expenses** - If anyone applying for medical benefits is employed, complete **Form E.** Also complete **Form E** for an employed spouse or parent of a child under age 18 if they live together. We will deduct the following from earnings if you provide proof of:

  - Federal, State, or City income taxes,
  - Social Security tax,
  - Transportation to work expenses at the most reasonable rate. We allow 19 cents per mile if you use your own car,
  - Special tools and uniforms required for the type of work performed,
  - Union dues, group life insurance premiums, group health insurance premiums and retirement plan withholding, if required as a condition of employment, and
  - For persons with disabilities, special work expenses, such as special transportation to work or a telecommunication device for the hearing impaired, that allow them to work. To be allowed as a deduction, the expenses must be paid by the applicant and not be reimbursed by an agency or other person.

- **Assets** - Send proof of each asset listed on **Form B**. If the person lives with his or her spouse, include the spouse's assets. This may include, but is not limited to, copies of current bank statements, certificates of deposit, life insurance policies, vehicle titles, prepaid burial contracts, trust documents, property deeds, and property tax bills.

- **Assets and Income of Spouse** - Provide proof of a spouse's assets and income, if anyone applying wants to transfer assets and give income to his or her spouse and the person applying:

  - lives in or intends to move to a long term care facility, or
  - lives in or intends to move to a supportive living facility, or
  - receives or has applied for services through the Department on Aging's Community Care Program.

MAIL-IN APPLICATION FOR MEDICAL BENEFITS

AGENCY USE ONLY
Date Received
Recycle Instruction pages 1 through 4 upon receipt of this application.
Case Number

If this application is submitted by a health care facility, enter the date of the applicant's admission to the facility _____, the actual or expected discharge date _____ and facility name _____.

Answer questions completely and accurately.

1. APPLICANT - The applicant is usually the person filling out this Form like the aged or person with a disability; a child's parent, guardian or other relative the child lives with; or a pregnant woman. The information you provide on this application is confidential and may only be used for purposes directly connected with the administration of the medical benefits programs.

Name (Last, First, Middle Initial)	**Daytime phone and best time to call you**
	( )

Street	**City**	**State**	**Zip**	**County**

Mailing Address (If different from above)

Language Preference	**Race or Ethnic Group**
English Spanish Other_____	White Black Hispanic Asian or Pacific Islander American Indian or Alaska Native Other: _____

2. PERSONAL INFORMATION

Enter the following for the person applying for medical benefits and all persons living with them. You do not have to give the Social Security Number or the U.S. citizenship status for a pregnant woman or anyone who does not want medical benefits. Attach an extra sheet if more space is needed.

A. Name (Last, First, Middle Initial)	**Sex**	**Birth Date**	**Relationship to Applicant** (wife, son, etc.)	**Wants Medical Benefits**	**U.S. Citizen**	**Social Security Number**
	M F		Applicant	Yes No	Yes No	
	M F			Yes No	Yes No	
	M F			Yes No	Yes No	
	M F			Yes No	Yes No	

2. PERSONAL INFORMATION (cont.)

B. Enter the mother's full name and father's full name for each person under age 18 applying for medical benefits. If a parent does not live with the child, also enter the parent's address.

Child's Name	Mother's Name and Address	Father's Name and Address

C. Is anyone applying a veteran or a spouse, child, widow(er) or parent of a veteran?	Yes No
If yes, enter the person's name and relationship to the veteran.	

D. Is anyone applying blind or have a disability?	Yes No
If yes, enter the person's name.	

E. Does everyone applying live in Illinois?	Yes No
If no, enter the person's name.	

F. Is anyone applying not a U.S. Citizen?	Yes No
If yes, enter the person's name and alien registration number. Attach documentation for the number.	

G. Does anyone applying live in a long term care or supportive living facility?	Yes No
If yes, enter the person's name.	
Was the person a resident in the facility prior to 07/01/96?	Yes No Unknown
Enter the facility's name, address and telephone number.	

H. Does anyone applying receive or has anyone applied for services through the Department on Aging's Community Care Program?	Yes No
If yes, enter the person's name.	

2. PERSONAL INFORMATION (cont.)

I. Is this an application to pay bills for someone who has died?	Yes No
If yes, enter the person's name and date of death.	

J. Does anyone applying have a legal guardian?	Yes No
If yes, who has the guardian?	
Name of guardian. Attach copy of guardianship papers.	

K. Is anyone applying pregnant or has anyone been pregnant within the last 3 months?	Yes No
If yes, enter the person's name, due date and number of babies expected.	

L. Did anyone applying receive any medical service during the 3 months before the month of this application?	Yes No
If yes, do you want us to decide if they can get help to pay these bills?	Yes No
If yes, what months?	

M. Is anyone applying covered by Medicare or other health insurance? If yes, complete Form A.	Yes No

N. Does anyone applying have a high cost medical condition?	Yes No
If yes, enter the person's name:	
Does the person have health insurance for the medical condition or can they get health insurance through a recent employer or through a relative's policy?	Yes No

O. Can anyone applying get free health insurance through a job or union?	Yes No
If yes, enter the person's name.	

3. SUPPORT PAID

Does anyone pay support for a person for whom they are legally responsible or for whom there is a court order for support? Attach proof.					Yes No
If yes, enter the person's name who pays support.					
Amount paid:		**How often paid:**		**Court ordered:**	Yes No

4. INCOME AND BENEFITS

Enter all money that anyone applying for medical benefits receives. If married and living with spouse, also enter any money the spouse receives. If under age 18 and living with a parent, also enter any money the parent receives. Enter the amount before deductions like taxes or insurance. Attach proof. Check all that apply and enter details below:

Social Security	Pensions/Retirement Benefits	Wages/Self-Employment	SSI
Veterans Benefits	Railroad Retirement Benefits	Trust or Annuity Payments	Child Support
Dividends or Interest	Royalties, Oil/Mineral Rights	Worker's Compensation	Rental Income
Alimony	Contributions	Farm Income	Disability Benefits
Unemployment Benefits	Other: _____		

Person Who Receives Income	Source of Income. If work, enter employer's name.	Amount	How Often?	If Social Security, enter Claim Number

5. CHILD CARE

Do you or does anyone living with you pay for child care so they can work? Attach proof.	Yes No

If yes, complete the following:

Child's Name	Care Giver Name	Monthly Amount	Person Paying for Care

READ AND SIGN

< I authorize officials with responsibilities for the health benefits program for which I have applied to verify all information on this form by any means including electronic means. I understand that I must cooperate in these efforts to verify information.

< If my application is approved, I give the State of Illinois the right to recover under the terms of any private or public health care coverage any amount for which I or a member of my household may be eligible.

< I understand that the State of Illinois will release information concerning medical services I have received for any purpose authorized by law.

< If I am approved for medical benefits, I give my right to collect medical support payments to the State of Illinois. I also understand that to receive medical benefits, I must cooperate with the State of Illinois to obtain medical support payments and establish paternity (if necessary) for members of my family unless I am declared exempt for a good cause.

< I agree to inform the Department of Human Services (DHS) within 10 days of any change in my address, household size, income, property, or living arrangements.

< I understand that anyone who knowingly misuses the health benefits card issued by the State of Illinois may be committing a crime.

< I declare, under penalty of perjury, that the statements I have made regarding the citizenship or immigration status of each person applying for medical benefits are true and correct.

< I understand that the immigration status of each person applying for medical benefits who is not a citizen of the United States will be verified with the Immigration and Naturalization Service (INS). This will require the disclosure to INS of certain identifying information which I have provided. The information received from INS may affect eligibility for medical benefits.

< I understand that if I am mentally and physically able to apply and I want someone else to apply for me, I must attach a written statement that gives the person permission. The statement must include the person's name, address, and phone number. The statement must say that I am still responsible for the information provided by the person.

I understand that if I have given false information or intentionally failed to disclose information for this application, I may be subject to criminal prosecution, civil action, or both. I certify under the penalty of perjury that I have read the completed application, forms and attached material and the information supplied is true and complete to the best of my knowledge.

Applicant's signature _____ Date _____
(If unable to sign, make a mark and have a witness sign next to your mark.)

If someone completed this application on behalf of the applicant, that person must sign and complete the information below.

Signature _____ Date _____ Phone _____
Name (print) _____ Relationship to Applicant _____
Address _____ City _____
State _____ Zip Code _____

If application is initiated by someone on behalf of the applicant, identify a relative, or other person, who can answer questions about the applicant's financial situation:

Name _____ Home Address _____
Relationship _____ Phone _____

FORM A
MEDICARE AND OTHER HEALTH INSURANCE

MEDICARE

Complete for anyone who has Medicare or attach a copy (front and back) of the Medicare card.		
Name	**Medicare Claim Number**	**Effective Date**
		Part A_____ Part B _____
		Part A_____ Part B _____

HEALTH INSURANCE

Complete for anyone covered by private health insurance or group health insurance, including a plan through their most recent employer or attach a copy (front and back) of the insurance card.

Name of Covered Person: _____

Policy Holder Name: _____ Policy Holder's SSN (optional) _____

Insurance Company _____ Certificate/Policy # _____

Medical Claims Mailed To:

Name _____ Street _____ City _____ State _____ Zip _____

Prescription Claims Mailed To:

Name _____ Street _____ City _____ State _____ Zip _____

Dates of Coverage: Begin Date _____ End Date _____

If insurance is through employer/union, enter employer/union.

Name _____ Street _____ City _____ State _____ Zip _____

Check all the following benefits provided:

Major Medical Dental Vision LTC Prescription

Monthly Premium Amount $_____

Name of Covered Person: _____

Policy Holder Name: _____ Policy Holder's SSN (optional) _____

Insurance Company _____ Certificate/Policy # _____

Medical Claims Mailed To:

Name _____ Street _____ City _____ State _____ Zip _____

Prescription Claims Mailed To:

Name _____ Street _____ City _____ State _____ Zip _____

Dates of Coverage: Begin Date _____ End Date _____

If insurance is through employer/union, enter employer/union.

Name _____ Street _____ City _____ State _____ Zip _____

Check all the following benefits provided:

Major Medical Dental Vision LTC Prescription

Monthly Premium Amount $_____

FORM B
ASSET INFORMATION

Complete only for persons who are blind, have a disability or are age 65 or older. If married and living with spouse, also enter any assets the spouse owns. If yes to any of the following, enter the details below. Attach proof.

Does anyone own any property such as a home, land or building?			Yes	No
Owner	**Address**	**Type**	**Value**	**Amount Owed**

Does anyone own a car, truck, motorcycle, boat, trailer or other vehicle?			Yes	No
Owner	**Type**	**Make/Model/Year**	**Value**	**Amount Owed**

Does anyone own any life insurance?			Yes	No
Owner	**Insurance Company**	**Policy Number**	**Face Value**	**Cash Value**

Does anyone own any of the following assets? Check all that apply:

checking account	trust funds	government bonds	burial plots	mineral/oil rights
savings	annuity	certificates of deposits	nursing home account	IRA
stocks, bonds	funeral/burial plans		money market account	other _____
mutual funds				

Owner	**Type of Asset**	**Account/Policy #**	**Value**	**Name of Bank, Company, etc.**

FORM C
TRANSFER OF ASSETS

Complete only for persons who live in a long term care facility or a supportive living facility or who intend to move to a long term care facility or a supportive living facility, or who receive or have applied for services through the Department on Aging's Community Care Program.

Have you or your spouse within the past 36 months sold or given away any assets; closed any bank accounts; or made any changes in the way an asset is held (such as, adding a name to a house deed or creating a trust or annuity)?	Yes	No
Have you or your spouse within the past 60 months: 1) Made any transfers from a revocable trust, or 2) created an irrevocable trust that does not permit payment to you? Do you or your spouse have an irrevocable trust that has stopped payment within the past 60 months?	Yes	No
If yes, enter details below. If you need more space, attach an additional page.		

What asset was transferred?				
Who transferred asset?	**Amount Received**	**To whom?**	**Date of Transfer**	**Market Value**
Describe the transfer. For example, was the asset sold, given away, or was there a change in the way the asset was held?				
Why was the asset transferred?				

What asset was transferred?				
Who transferred asset?	**Amount Received**	**To whom?**	**Date of Transfer**	**Market Value**
Describe the transfer. For example, was the asset sold, given away, or was there a change in the way the asset was held?				
Why was the asset transferred?				

FORM D
TRANSFER OF ASSETS AND INCOME TO SPOUSE

Complete only for persons who are married and live in a long term care facility or a supportive living facility or who intend to move to a long term care facility or a supportive living facility, or who receive or have applied for services through the Department on Aging's Community Care Program.

Do you want to transfer assets to your spouse?	Yes	No
If yes, attach copies of your spouse's assets.		

Do you want to give income to your spouse?	Yes	No
If yes, attach copies of your spouse's income.		

Does your spouse live in a long term care facility or a supportive living facility?	Yes	No

Does your spouse receive or has your spouse applied for services through the Department on Aging's Community Care Program?	Yes	No

Does your spouse receive medical benefits through the Department of Human Services or the Department of Public Aid?	Yes	No
If yes, enter case number:		

FORM E
EMPLOYMENT EXPENSES

Complete only for employed persons who are blind, have a disability or are age 65 or older. Also enter the employment expenses for an employed spouse or parent of a child under age 18 if they live together.

Employed person's name:				
Amount received before deductions (gross amount):				
How often paid:	Weekly	Every Two Weeks	Bi-Monthly	Monthly
Federal, State and City taxes withheld:		**Social Security tax withheld:**		
Does the person buy or bring lunch to work?	Buy Lunch	Bring Lunch		
Does the person buy uniforms or special tools?	Yes	No		
If yes, enter the items bought, how often, and cost. Attach proof.				
How does the person get to and from work?	Own Car	Bus	Other	
If person uses own car, how many miles to work?				
If person takes bus, what is the fare to work?				
If other, enter type and cost. Attach proof.				
Must the person pay union dues, group life insurance premiums, group health insurance premiums, or retirement plan withholding as a condition of employment?	Yes	No		
	Monthly amount:$_____			

Employed person's name:				
Amount received before deductions (gross amount):				
How often paid:	Weekly	Every Two Weeks	Bi-Monthly	Monthly
Federal, State and City taxes withheld:		**Social Security tax withheld:**		
Does the person buy or bring lunch to work?	Buy Lunch	Bring Lunch		
Does the person buy uniforms or special tools?	Yes	No		
If yes, enter the items bought, how often, and cost. Attach proof.				
How does the person get to and from work?	Own Car	Bus	Other	
If person uses own car, how many miles to work?				
If person takes bus, what is the fare to work?				
If other, enter type and cost. Attach proof.				
Must the person pay union dues, group life insurance premiums, group health insurance premiums, or retirement plan withholding as a condition of employment?	Yes	No		
	Monthly amount:$_____			

FORM F
ABSENT SPOUSE INFORMATION

Enter the following information for each absent spouse.

Absent Spouse's Name			Spouse of Whom?		
Street	**Apt. No.**	**City**	**State**	**Zip**	**County**
Social Security Number					
Monthly Gross Income					
Source of Income (Include employer's name and address)					

Absent Spouse's Name			Spouse of Whom?		
Street	**Apt. No.**	**City**	**State**	**Zip**	**County**
Social Security Number					
Monthly Gross Income					
Source of Income (Include employer's name and address)					

FORM G
KIDCARE REBATE FORM

Complete this form if your children are already covered by health insurance by your employer or other private health insurance plan or if you have arranged for health insurance for them to begin soon. Follow the steps below:

1) Complete Part A;
2) Have the policyholder's employer or personal insurance agent complete Part B and return it to you; and
3) Attach this completed form to the completed application prior to mailing.

Part A - Employee/Policyholder Section - *To be completed by the employee/policyholder*.

Employee/Policyholder's Last Name_____ First Name_____

Address _____ City_____ State___ Zip_____

Social Security Number_____ Phone ( )_____

(SSN is required in order for the state to make payments to the policyholder.)

Name(s) of children for whom you are applying for KidCare Rebate: _____

Employee/Policyholder Attestation and Signature - I agree to notify the KidCare Hotline immediately at toll-free 1-866-4-OUR-KIDS (1-866-468-7543) (TTY: 1-877-204-1012) if the insurance is terminated, persons are added to or deleted from the policy or the coverage or policyholder changes. I authorize my employer, plan administrator and insurance company to provide the information requested in Part B below for the purpose of determining eligibility for KidCare. I also authorize my employer, plan administrator and insurance company to verify my coverage and any of the information below at any time during my participation in KidCare.

Signature of Employee/Policyholder _____

Part B - Employer/Insurance Agent Section - *To be completed by the employer or by the policyholder's insurance agent if the policy is not provided through an employer.*

Note to Employer/Insurance Agent: The above named employee/policyholder is applying for a program called KidCare that may help cover the cost of their children's health insurance premiums. Please assist them by completing the information below about their coverage and returning the form to the employee/policyholder as soon as possible. (As used below, employee applies to an employee or private policyholder.)

Employer (if employer policy) _____

Employer Address _____ City_____ State___ Zip_____

Person completing this form _____ Phone ( )_____ Fax ( )_____

Insurance Company_____ Policy Number_____ Group Number_____

Check which of the following benefits are covered: ☐ Physician Services ☐ Hospital Inpatient Services

Amount of Premium Paid by Employee $_____ (Include amounts paid for dental, vision and prescription coverage)

Premiums are paid: ☐ weekly ☐ every 2 weeks ☐ twice a month ☐ monthly
☐ every 2 months ☐ quarterly ☐ semi-annually ☐ annually

Persons covered by the employee premium contribution _____ _____ _____ _____ _____

Does the employer pay 100% of the cost of the employee's coverage? ☐ Yes ☐ No

If NO, how much of the amount listed above is for coverage of the employee only (single rate)? $_____
(Include amounts for dental, vision and prescription coverage)

Enrollment Period for Policy _____ Date the Premium Listed Above Began/Begins_____

Date of Next Scheduled Change in Premium _____

Authorized Signature of Employer/Agent _____ Date_____